Division of
Health Care
Finance & Administration

Health Care
Innovation Initiative

EPISODE DESIGN FEEDBACK SESSION

MAY 16, 2017

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BEHAVIORAL HEALTH EPISODES

Episodes Included in the Behavioral Health Session

Attention Deficit and Hyperactivity Disorder (ADHD)

Oppositional Defiant Disorder (ODD)

Approach to the feedback session and objectives for today's discussion

Approach & Process

1. **May 2017:** Gather feedback from Stakeholders across the state on the first 20 episodes implemented
2. **May-June 2017:** Conduct analysis to inform decision of how to incorporate feedback
3. **Fall 2017:** Release memo to public with all episode changes
4. **January 2018:** Incorporate selected changes into program for calendar year 2018

Objectives & Scope for Today

1. Briefly review the background and objectives of the Tennessee Health Care Innovation Initiative & Episodes of care
2. Review feedback received prior to the meeting regarding the behavioral health episodes
3. Listen to and capture feedback *specific* to the behavioral health episodes
4. Capture feedback on the program overall

The primary purpose of today's session is listening; the state will respond to and incorporate feedback as appropriate over the coming months

Tennessee Health Care Innovation Initiative

We are **deeply committed** to reforming the way that we pay for healthcare in Tennessee

Our goal is to **pay for outcomes and for quality care**, and to reward strongly performing providers

We plan to have value-based payment account for the **majority of healthcare spend** within the next three to five years

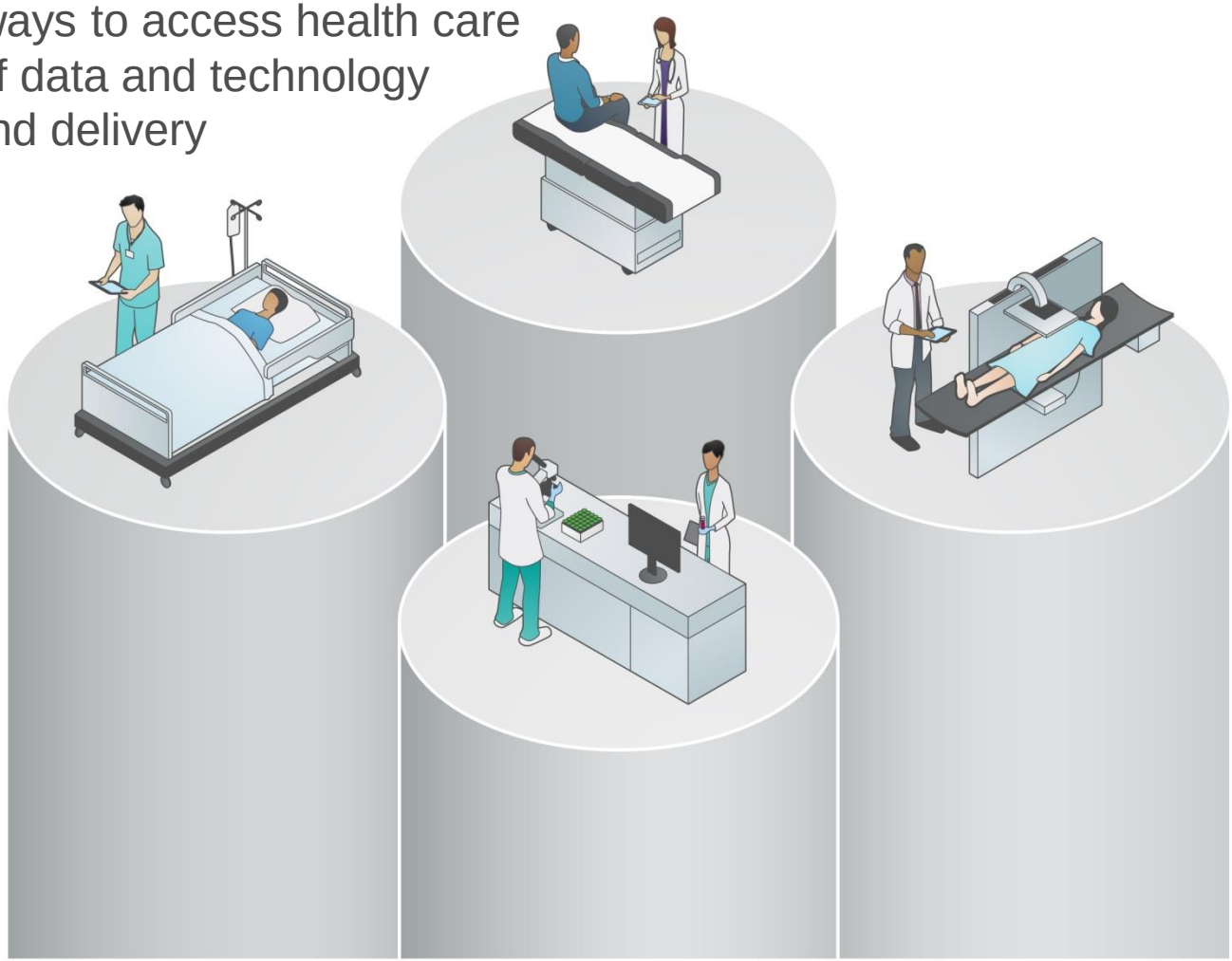
By **aligning on common approaches** we will see greater impact and ease the transition for providers

We appreciate that hospitals, medical providers, and payers have all demonstrated a **sincere willingness** to move toward payment reform

By working together, we can make significant progress toward **sustainable medical costs and improving care**

What changes do we see for the health care system?

- Silos are starting to come down
- Growth in new ways to access health care
- Increased use of data and technology
- New payment and delivery models



Over 40 episodes of care have been designed over the last 4 years

Design year & wave		Episode
2013	1	Perinatal
		Asthma acute exacerbation
		Total joint replacement
2014	2	COPD acute exacerbation
		Colonoscopy
		Cholecystectomy
		PCI - acute
		PCI – non acute
2015	3	GI hemorrhage
		EGD
		Respiratory Infection
		Pneumonia
		UTI - outpatient
		UTI – inpatient
	4	ADHD
		CHF acute exacerbation
		ODD
		CABG
		Valve repair and replacement
		Bariatric surgery
2016	5	Breast biopsy
		Breast cancer, medical oncology
		Breast cancer, Mastectomy
		Otitis media
		Tonsillectomy
		Anxiety
		Non-emergent depression
	6	Skin and soft tissue infections
		Neonatal (Age 31 weeks or less)
		Neonatal (Age 32 to 36 weeks)
		Neonatal (Age 37 weeks or greater)
		HIV
		Pancreatitis
		Diabetes acute exacerbation
2017	7	Spinal fusion
		Spinal decompression (without spinal fusion)
		Femur/pelvis fracture
		Knee arthroscopy
		Ankle sprains, strains, and fractures
		Wrist sprains, strains, and fractures
		Shoulder sprains, strains, and fractures
		Knee sprains, strains, and fractures
		Back/neck pain

Results for First Three Episodes

- Perinatal, total joint replacement and acute asthma exacerbation episodes showed total costs were reduced while quality was maintained in CY 2015.

Perinatal: 3.4% decrease in cost

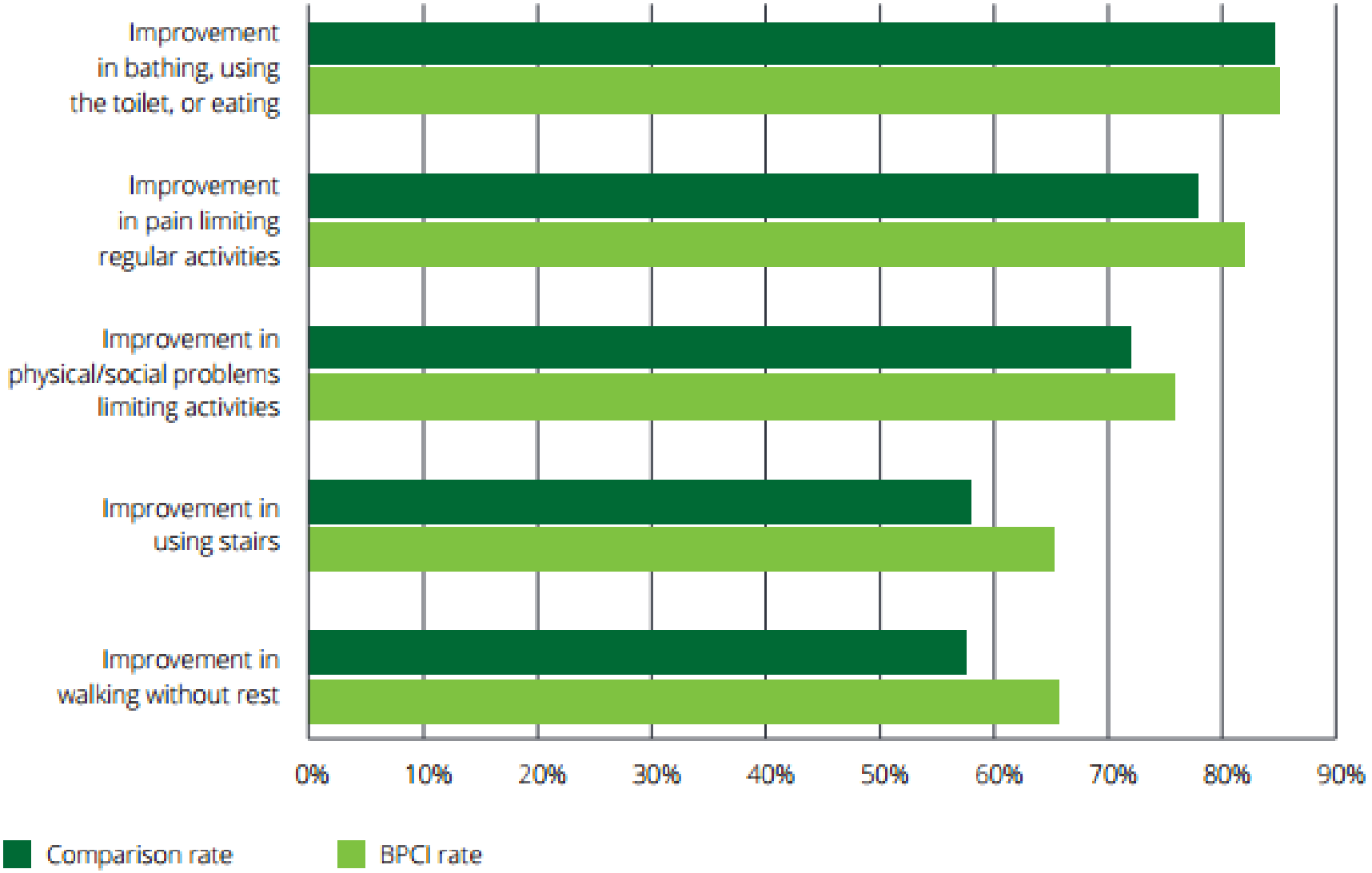
Acute asthma exacerbation: 8.8% decrease in cost

Total joint replacement: 6.7% decrease in cost

Doctors and hospitals reduced costs while maintaining quality of care

Wave 1 episodes reduced costs by $11.1 million
(assuming a 3 percent increase would have taken place in the absence of this initiative)

Bundled services for major joint replacement of the lower extremity showed improvement in mobility measures for patients



Source: CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 2 Evaluation & Monitoring Annual Report, 2016.

Status of the launched Behavioral Health Episodes

	First Preview Report Sent	Performance Period
ODD (Wave IV)	Spring 2016	CY 2017
ADHD* (Wave IV)	Spring 2016	CY 2018

**The performance period for the ADHD episode was delayed until CY 2018. Preview reports will continue for CY 2017.*

ADHD episode definition

Area	Episode definition
1 Identifying episode triggers	▪ An ADHD episode is triggered by a professional claim that has: – **A primary diagnosis of ADHD** (ICD-9 diagnosis code 314 – Hyperkinetic syndrome of childhood), or – **A secondary diagnosis of ADHD and a primary diagnosis of a symptom of ADHD**[1] ▪ This professional visit must also have a procedure code that is for assessment, therapy, case management, or physician services
2 Attributing episodes to quarterbacks	▪ The quarterback is the **provider or group with the plurality of ADHD-related visits** during the episode ▪ The contracting entity ID with the plurality of ADHD visits will be used to identify the quarterback
3 Identifying services to include in episode spend	▪ The length of the ADHD episode is **180 days**. During this time period the following services are included in episode spend: – All inpatient, outpatient, professional, and long-term care claims with a **primary diagnosis of ADHD** – All inpatient, outpatient, professional, and long-term care claims with a **secondary diagnosis of ADHD and a primary diagnosis of a symptom of ADHD** – Pharmacy claims with **eligible therapeutic codes**
4 Risk adjusting and excluding episodes	▪ Episodes affected by **factors that make them inherently more costly than others are risk adjusted.** The list of factors recommended for testing will be provided in the DBR ▪ Episodes which are **not comparable** or affected by factors that make them inherently more costly but that **cannot be risk adjusted for are excluded**. There are three types of exclusions: – Business exclusions: Available information is not comparable or is incomplete[2] – Clinical exclusions: Patient's care pathway is different for clinical reasons: ▫ These include age (<4 or >20), attempted suicide, autism, bipolar, BPD, conduct disorder, delirium, dementia, DMDD, dissociative disorders, homelessness, homicidal ideation, intellectual disabilities, manic disorders, psychoses, PTSD, schizophrenia, specific psychosomatic disorders (e.g. factitious disorder), substance abuse (prescription and illicit), children in state custody through the DCS, and members with level 1 case management[3] – High cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean
5 Determining quality metrics performance	**Tied to gain sharing:** – Percentage of valid episodes that meet the minimum care requirement. The minimum care requirement is set at 5 visits/claims with a related diagnosis code during the episode window. These may be a combination of physician visits, therapy visits, level I case management visits, or pharmacy claims for treatment of ADHD – Rate of long-acting medication use by age group (4 and 5, 6 to 11, and 12 to 20) – Average number of therapy visits per valid episode for the 4 and 5 age group ▪ **Not tied to gain sharing:** – Average number of E&M and medication management visits per valid episode – Average number of therapy visits per valid episode by age group (6 to 11 and 12 to 20) – Average number of level I case management visits per valid episode – Percentage of valid episodes with medication by age group (4 and 5, 6 to 11, and 12 to 20) – Percentage of valid episodes for which the patient has an E&M and medication management,, therapy, or level I case management visit within 30 days of the triggering visit

1 Symptoms of ADHD are identified by ICD-9 diagnosis codes 312.30 – Impulse control disorder and 312.9 - Unspecified disturbance of conduct)
2 Episodes with inconsistent enrollment, third-party liability, or dual eligibility; episodes where triggering procedure occurs in a Federally Qualified Health Center or Rural Health Clinic; episodes that cannot be associated with a quarterback ID; episodes with zero triggering professional spend; episodes where total non-risk-adjusted spend is within the bottom 2.5% of all episodes; and episodes where patients expired in the hospital or left against medical advice
3 The level 1 case management exclusion will be revisited before the 2018 performance period

ODD episode definition

Area	Episode definition
1 **Identifying episode triggers**	▪ An ODD episode is triggered by a professional claim that has: – A **primary diagnosis of ODD** (ICD-9 diagnosis code 313.81 – Oppositional defiant disorder), or – A **secondary diagnosis of ODD and a primary diagnosis of a symptom of ODD**[1] ▪ This professional visit must also have a procedure code that is for assessment, therapy, case management, or physician services
2 **Attributing episodes to quarterbacks**	▪ The quarterback is the **provider or group with the plurality of ODD-related visits** during the episode ▪ The contracting entity ID with the plurality of ODD visits will be used to identify the quarterback
3 **Identifying services to include in episode spend**	▪ The length of the ODD episode is **180 days**. During this time period the following services are included in episode spend: – All inpatient, outpatient, professional, and long-term care claims with a **primary diagnosis of ODD** – All inpatient, outpatient, professional, and long-term care claims with a **secondary diagnosis of ODD and a primary diagnosis of a symptom of ODD** – Pharmacy claims with **eligible therapeutic codes**
4 **Risk adjusting and excluding episodes**	▪ Episodes affected by **factors that make them inherently more costly than others are risk adjusted.** The list of factors recommended for testing will be provided in the DBR ▪ Episodes which are **not comparable** or affected by factors that make them inherently more costly but that **cannot be risk adjusted for are excluded**. There are three types of exclusions: – Business exclusions: Available information is not comparable or is incomplete[2] – Clinical exclusions: Patient's care pathway is different for clinical reasons: ▫ These include age (<4 or >18), antisocial personality disorder, attempted suicide, autism, BPD, conduct disorder, delirium, dementia, DMDD, dissociative disorders, homicidal ideation, intellectual disabilities, manic disorders, psychoses, PTSD, schizophrenia, specific psychosomatic disorders (e.g. factitious disorder), substance abuse (prescription and illicit) – High cost outlier exclusions: Episode's risk adjusted spend is three standard deviations above the mean
5 **Determining quality metrics performance**	▪ **Tied to gain sharing:** – Percentage of valid episodes that meet the minimum care requirement. The minimum care requirement is set at 6 therapy and/or level I case management visits with a related diagnosis code during the episode window ▪ **Not tied to gain sharing:** – Percentage of valid episodes with no coded behavioral health comorbidities for which the patient received behavioral health medications – Percentage of valid episodes that had a claim with ODD as the primary diagnosis in the prior year – Average number of visits (E&M and medication management, therapy, and case management) per valid episode – Average number of therapy or level I case management visits per valid episode

1 Symptoms of ODD are identified by ICD-9 diagnosis codes 312.9 - Unspecified disturbance of conduct, 313.89 - Other emotional disturbances, and 93 ICD-9 codes for substance-related disorders

2 Episodes with inconsistent enrollment, third-party liability, or dual eligibility; episodes where triggering procedure occurs in a Federally Qualified Health Center or Rural Health Clinic; episodes that cannot be associated with a quarterback ID; episodes with zero triggering professional spend; episodes where total non-risk-adjusted spend is within the bottom 2.5% of all episodes; and episodes where patients expired in the hospital or left against medical advice

Examples of Changes made based on previous Episode Design Feedback Sessions

1. **All Episode Feedback**

- *Aligning readmission logic with future waves of episodes.*

In 2015, all wave one episodes of care included readmissions based on an exclusionary logic. Following the Feedback Session, readmissions were based on an inclusionary logic, meaning that only specifically related admissions are now included.

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2. **Episode: Attention-Deficit/ Hyperactivity Disorder (ADHD)**

- *Exclude homeless patients from the ADHD episode.*

A child experiencing homelessness can be associated with a unique ADHD patient journey and should be excluded.

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3. **Episode: Attention-Deficit/ Hyperactivity Disorder (ADHD)**

- *The utilization of therapy quality metric will be updated to stratify episodes by age*

The utilization of therapy captures the average number of therapy visits per valid episode. The quality metric will be divided into three age groups: 4 to 5 years, 6 to 11 years and 12 to 20 years. The 4 to 5 years age group will be linked to gain-sharing.

Behavioral Health Episode feedback received to date

Area	Feedback
Identifying episode triggers	▪ Remove level II case management from the triggering logic for the ADHD episode.
Attributing episodes to quarterbacks	▪ Review episodes in which laboratories are quarterbacks for the ADHD and ODD episodes.
Identifying services to include in episode spend	▪ None
Risk adjusting and excluding episodes	▪ Exclude episode if member fall into two behavioral health episodes. ▪ Exclude Disruptive Mood Dysregulation Disorder from the ODD episode. ▪ Exclude Tennessee Health Link codes from behavioral health episodes of care.
Determining quality metrics performance	▪ None

Topics for Discussion

Design Dimensions

1. Identifying episode triggers
2. Attributing episodes to quarterbacks
3. Identifying services to include in episode spend
4. Risk adjusting and excluding episodes
5. Determining quality metrics performance

General Episode Feedback

Next steps following this feedback session

- **Review** all feedback received both prior and during the feedback session
- **Analyze** the potential changes and possible impact on episode design
- **Release** memo summarizing changes to episode design in the late-summer
- **Incorporate** changes that need to be made for the 2018 performance period

Thank you for participating!

Please contact payment.reform@tn.gov with any questions or visit our website at: www.tn.gov/hcfa/topic/episodes-of-care